Department of Managed Health Care
ELECTRONIC FILING SIGNATURE VERIFICATION

Original hardcopy **MUST** be returned to : **DMHC/ ATTN: Licensing Administration**
980 9th Street, Suite 500
Sacramento, CA 95814

1.0 IDENTIFICATION OF PARTIES

This agreement is between the State of California, Department of Managed Health Care and California Health Care Service Plans, hereinafter referred to as "HCSP".

Health Care Service Plan (HCSP) INFORMATION

HCSP Name (legal)	HCSP License Number **933-**
DBA (if applicable)	

Address (number, street)	City	State	ZIP Code

INDIVIDUAL INFORMATION

Name (First, Last) Phone Number

Title E-mail

REQUESTED ACTION:

Choose one or more check box(es) as appropriate: (***Requires Signature below.***)

☐ Individual Login/Password (web portal access)

☐ Signatory Contact (for Electronic Execution of eFile)

☐ Business Contact

Web Portal Applications

If requesting Login/Password access to the web portal, please select the web-based application(s) you are authorized to have access to:

☐ eFile

☐ Technical Assistance Guide

☐ Quarterly Grievance Report

☐ Financial Solvency Reporting

☐ Health Plan Financial Statement Reporting

☐ Claims Settlement Practices and Dispute Resolution Report

SIGNATURE

Signature of Individual (original required; ***use blue ink***) _____ Date _____

The undersigned, being fully authorized to execute on behalf of the above identified health care service plan, hereby certifies under penalty of perjury pursuant to the laws of the State of California as to this Electronic Filing Signature Verification and any other electronically submitted application, amendment, material modification, or other required filing and each exhibit and attachment thereto, that the undersigned knows the contents thereof and that the statements therein are true and correct. The undersigned agrees that all future documents filed electronically with the Department of Managed Health Care pursuant to this verification which include the typed name of the undersigned will have the same force and effect as if the undersigned had signed the document by hand and subject to this certification under penalty of perjury.

Authorized by (must be Signatory on file with DMHC for this Plan) _____ Date _____
SIGNATURE

_____
PRINT NAME